South Carolina Department of Health & Environmental Control
Office of Primary Care
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Please Fax or Mail Completed Form

PHYSICIAN INTAKE FORM

The Office of Primary Care works to assist medically underserved (rural and urban) populations improve their access to primary health care. To allow us to match you with compatible practice opportunities, from our database, *please* return this completed form and a current CV. The information you provide will be treated with confidentiality and will only be released with your request/approval.

First Name _____ Middle Initial _____ Last Name _____ Date Available _____

Home Address _____ City _____ State _____ Zip _____

E-mail _____ Home phone _____ Work phone _____ Cell phone _____ Pager _____

May we call you?

☐ Yes If yes, please state best time(s), place and format (e.g. pager) _____

☐ No

Education and Practice History/Information

Degree: Specialty:

☐ MD ☐ FP ☐ OB/GYN ☐ PSYCH ☐ IM ☐ PEDS ☐ OTHER _____

☐ DO

Medical School: Name _____ City/State _____ Graduation Date _____

Residency: Name _____ City/State _____ Graduation Date _____

Subspecialty: Type _____ Fellowship: Name _____ City/State _____

Board Status

☐ Board Certified

☐ Board Eligible

☐ Will be Eligible _____ (date)

Loans/obligations

☐ NHSC, length of time _____

☐ State of SC _____

☐ Medical School Loans _____

☐ Other _____

Credentialed by:

☐ USMLE

☐ FLEX # sittings _____

☐ National Board

☐ State

☐ Other, describe _____

If currently employed

please state: Name of Employer/Practice/Hospital _____ City, State, County _____ Employment Dates _____

Practice Considerations

Are you willing to do OB? (Family Practice only) ☐ Yes ☐ No ☐ No Preference
Will you accept Medicaid and Medicare assignments? ☐ Yes ☐ No ☐ No Preference
Do you desire hospital privileges? ☐ Yes ☐ No ☐ No Preference

Type of practice desired: (rank each from 1st to 9th based on preference)

____ Multi Specialty Group ____ Solo ____ State Institution
____ Single Specialty Group ____ Solo w/ Associate ____ Rural Health Clinic
____ Partnership ____ Hospital Based ____ Community/Migrant Health Center

Minimum salary requirements? _____

What is your geographic preference? (Please add any information about where you want to live, help us place you.)

☐ Coastal ☐ No Preference
☐ Midlands Comments: _____
☐ Upstate

What size community would you prefer? (rank from 1 to 4)
(Remember that our focus is on rural communities) ____ less than 5,000 ____ 25,000 – 50,000 ____ 5,000 – 10,000
____ 50,000 – 100,000 ____ 10,000 – 25,000 ____ 100,000 – 250,000

Miscellaneous:

Please check one: ☐ US Citizen ☐ Permanent US Visa ☐ Other type of Visa _____
If you are bilingual, please tell us which language(s)? _____ _____ _____

What is your reason for leaving your current position? _____

Personal Data (This information if OPTIONAL but it will help to better match you and your family to a community and a practice)

Birth Date: _____ Marital Status: ☐ Married ☐ Significant Other ☐ Single ☐ Divorced

City/State where raised: _____

Name of spouse/significant other and any special needs/interests: _____
_____

Long-term professional goals: _____

Any added information you would like to share to help us to match you and your family to a suitable practice opportunity and community?

_____
_____
_____
_____
_____
_____
_____